CIVIL AIR PATROL
Headquarters
Maryland Wing
P.O. Box 18341
Baltimore MD 21240-8341

MDWG Supplement 1
CAPR 160-2
3 February 2002

Medical

AUTHORIZED MEDICAL CARE AT AIR FORCE HOSPITALS

CAPR 160-2, 3 July 1989, is supplemented as follows:

4. Added. Each cadet and senior member should carry a fully filled out MDWGF 90, Medical Treatment Authorization, at all times while participating in CAP activities. This will assist in obtaining medical assistance in case of an illness or injury. Members should fill out new MDWGF 50s anytime the information changes. Units should review MDWGF 90s for currency at least annually.

JOHN F. REUTEMANN III, C/Lt Col, CAP
Administrative Officer

LAWRENCE L. TRICK, Col, CAP
Commander

Attachments:
1. MDWGF 90 (Medical Treatment Authorization)

Supersedes MDWG Supplement 1, 1 January 1999
OPR: DP
Distribution: In accordance with CAPR 5-4

HEADQUARTERS
MARYLAND WING CIVIL AIR PATROL
UNITED STATES AIR FORCE AUXILIARY
P.O. BOX 18341
BALTIMORE, MD 21240-8341

MEDICAL TREATMENT AUTHORIZATION

Date _____

FOR CADETS ONLY:

I give permission for any licensed and recognized medical facility to take whatever measures are required to render medical service, including but not limited to emergency surgery, to treat the illness or injury that has affected my dependent until further authorization can be obtained.

_____
Signature of parent/guardian

FOR SENIORS ONLY

Being of legal age, I give permission for any licensed and recognized medical facility to take whatever measures are required to render medical services, including but no limited to emergency surgery, to treat the illness or injury that has affected me until further authorization can be obtained.

_____
Signature

PERSONAL DATA

Name: _____ Male Female DOB: _____

Address: _____ MD _____

(Street) (City) (State) (Zip)

Primary Notification: _____ Telephone: _____

Secondary Notification: _____ Telephone: _____

Height: _____ Weight: _____ Blood Type: _____

Allergies:

_____

_____

_____

Immunizations Years: _____

_____

Current Medication: _____

Current/Past Medical History: _____

_____

_____

_____

Family Physician: _____ Telephone: _____

Address: _____ MD _____

(Street) (City) (State) (Zip)

Medical Plan/Health Insurance: _____

Policy or ID # _____

Notification Telephone # _____

_____
Commander Signature and Date